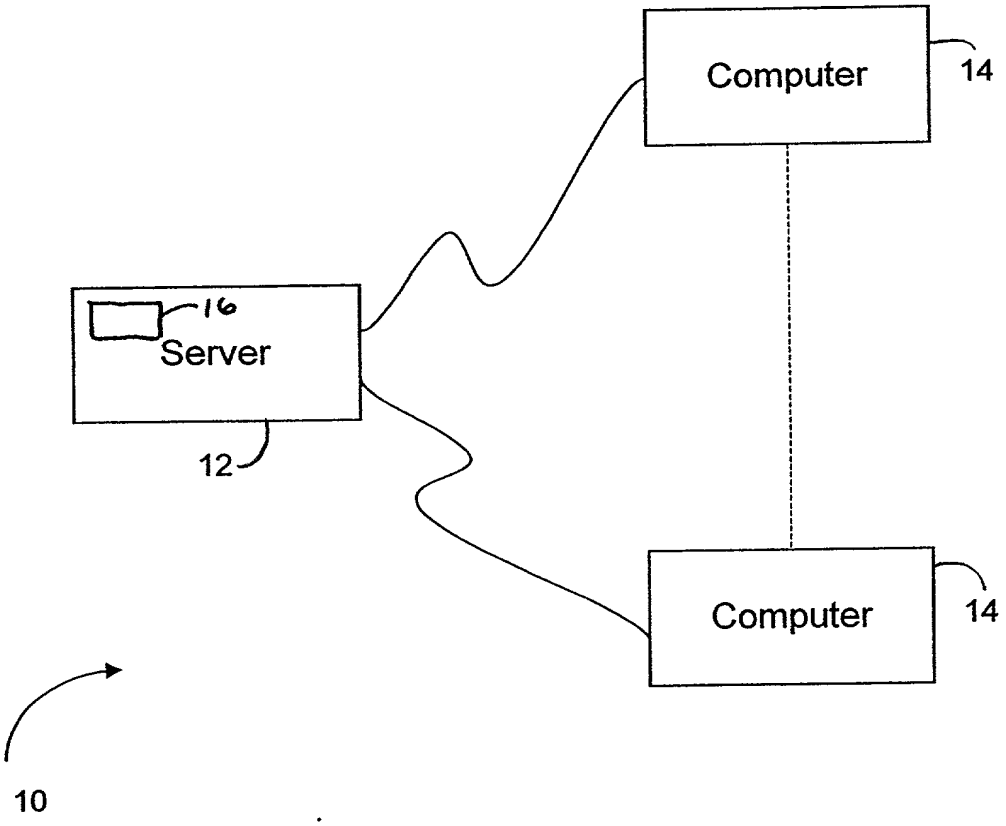

FIG. 1

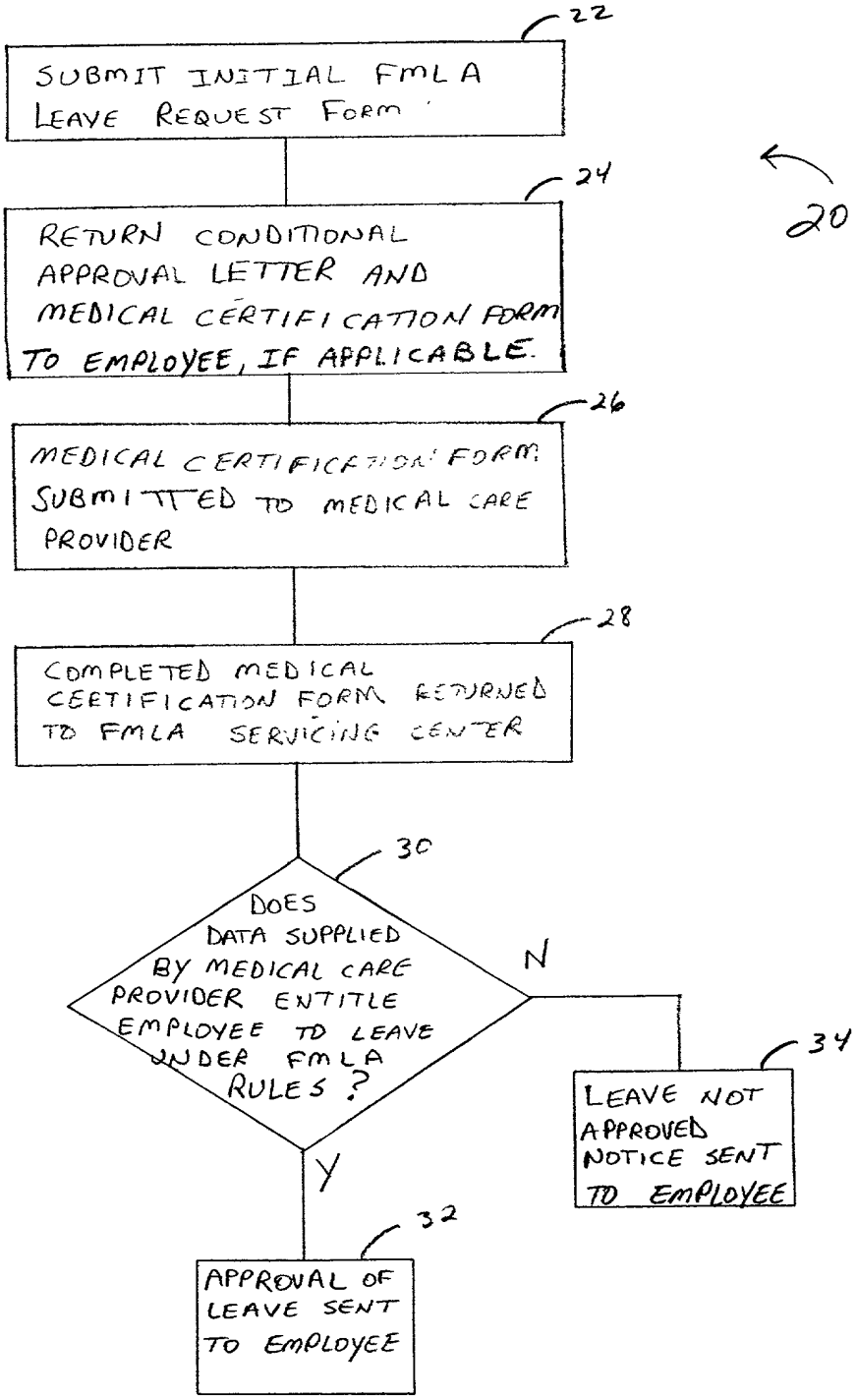
22
SUBMIT INITIAL FMLA LEAVE REQUEST FORM
24
RETURN CONDITIONAL APPROVAL LETTER AND MEDICAL CERTIFICATION FORM TO EMPLOYEE, IF APPLICABLE.
20
26
MEDICAL CERTIFICATION FORM SUBMITTED TO MEDICAL CARE PROVIDER
28
COMPLETED MEDICAL CERTIFICATION FORM RETURNED TO FMLA SERVICING CENTER
30
DOES DATA SUPPLIED BY MEDICAL CARE PROVIDER ENTITLE EMPLOYEE TO LEAVE UNDER FMLA RULES ?
N
34
LEAVE NOT APPROVED NOTICE SENT TO EMPLOYEE
Y
32
APPROVAL OF LEAVE SENT TO EMPLOYEE

FIG. 2

3/5

50

1 2 3

Initial FMLA Leave Request Form

Any incomplete information will delay the processing of this request.

52 **If you have any questions, please call the FMLA Center toll free at 877-555-FMLA/(877)-555-3652.**

1 Form submitted by: _____ 86 *if different from employee* _____ 88 *GE Capital Business* Date: _____ 66

Employee Name: John Smith 58 SS No.: 123-45-6789 64

Home address: _____ 60 (Street) (City) (State) (ZIP)

Home phone: _____ 62 MGR: _____ 70 HR Rep.: _____ 74

Date of Hire: _____ 68 (mm/dd/yy) MGR phone: _____ 72 HR Rep. phone: _____ 76

Work Location: _____ (City/State) Current Work Schedule: _____ 82 (Days/Hours per week)

Work phone: _____ 80 78 84 ☐ **Check this box if you are applying for disability benefits.**
(note: you must call the disability center to apply for disability benefits)

2 54 Reason for Leave

Please check (✔) the reason for the leave you are requesting.

HOSPITAL

☐ Inpatient hospital stay, recovery from stay or treatment related to stay. 90

PREGNANCY

92 ☐ Incapacity due to pregnancy and prenatal care (before the child is born).
Expected delivery date: _____ 104
or

NEW CHILD

94 ☐ Time to care for a newborn child or a newly placed adopted or foster care child (for moms ***and*** dads).

PERSONAL MEDICAL CONDITION

96 ☐ Too sick to work for more than three consecutive days (including non-work days), ***and*** saw a health care provider twice;
or

98 ☐ Too sick to work for more than three consecutive days (including non-work days), ***and*** saw a health care provider once ***and*** given a continuing regimen of treatment (e.g., therapy, medication);
or

100 ☐ Incapacitated by or out to receive treatment for a serious chronic or permanent health condition (e.g., asthma, diabetes, cancer).

FAMILY

102 ☐ To take care of/provide support for a sick eligible family member who falls into one of the categories above (except care of a new child).

_____ 106
(Name of family member & relationship to you)

3 56 Type of Leave

Please check (✔) the type of leave you are requesting.

108 ☐ **Full, Continuous Leave**

Requested time period:

Begin date: _____ 110 (mm/dd/yy) to _____ 112 (mm/dd/yy) end date

114 ☐ **Reduced Schedule**

Requested reduced work schedule:

_____ 116 hrs./day

_____ 118 hrs./week

_____ 120 days/week

Time period for which you are requesting the reduced schedule:

Begin date: _____ 122 (mm/dd/yy) to _____ 124 (mm/dd/yy) end date

126 ☐ **Intermittent Leave** (i.e., occasional, episodic)

If the medical condition is occasional or episodic, we require a specific time period for coverage under the FMLA (up to 1 year maximum.)

Begin date: _____ 128 (mm/dd/yy) to _____ 130 (mm/dd/yy) end date

FIG. 3

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1 2 3

Medical Certification for FMLA - Employee

Take this form to your medical provider for certification.

For questions regarding this form call 877-555-FMLA/877-555-3652. Return to the FMLA Center by _____

Name: John Smith (148) ***SS No.:*** 123-45-6789 (150)

1 Reason for Leave — Medical Provider must check (✔) any and all that apply.

PREGNANCY — *I certify that the above patient is/has been/will be:* (142)

- ☐ **Incapacitated*** due to pregnancy.
- ☐ Receiving prenatal care. — Expected delivery date: _____

MEDICAL CONDITION — *I certify that the above patient is/has been/will be:*

- ☐ **Incapacitated*** for **more than 3 consecutive days** and received **treatment at least 2 times** for this condition.
- ☐ **Incapacitated*** for **more than 3 consecutive days** and received **treatment** for this condition and prescribed a regimen of continuing treatment (i.e. therapy, Rx).
- ☐ **Incapacitated*** by or **out of work** to receive treatment for a **chronic** serious health condition which 1) requires **periodic visits**/treatment and 2) continues over extended period of time and 3) causes **episodic** or **continuing incapacity***.
- ☐ **Incapacitated*** by a **permanent/long-term condition** for which patient is undergoing continuing treatment (i.e. Alzheimer's, severe stroke).
- ☐ **Out of work** to undergo **examination/testing** for a condition that would likely fall into one of the categories listed above or require inpatient stay.

*** Unable to work or perform regular daily activities.**

HOSPITAL STAY — *I certify that the above patient is/has been/will be:*

- ☐ **Inpatient** in a **hospital, hospice, or residential** medical care **facility**.
- ☐ Out of work to receive **treatment** for a condition connected to previous inpatient stay.
- ☐ **Recovering** from inpatient stay and incapacitated (unable to work or perform regular daily activities).

2 Dates/Time of Leave — Medical provider must indicate dates and times of leave

(144)

Continuous Leave: (If Requested) — *I certify that the above patient has a medical need for leave as described.*

Requested time period — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

Reduced Hours: (If Requested) — *I certify that the above patient has a medical need for leave as described.*

Requested reduced hours schedule _____ hrs./day _____ hrs./week _____ days/week

Requested time period — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

Intermittent (i.e., occasional, episodic) Leave: (If Requested) — *I certify that the above patient has a medical need for leave as described.*

Requested intermittent schedule _____ hrs./day _____ hrs./week _____ days/week

Indicate approximate duration of medical condition — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

(146)

3 Signature Stamp — Medical provider must sign and return form to the FMLA Center

Medical Provider Signature: _____ (152) ***Phone:*** _____ (154) ***Fax:*** _____ (156)

Print Name: _____ (158) ***Type of Practice:*** _____ (160) (field of specialty, if any)

Address: _____ (162) (city) (state) (zip)

FIG. 4

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Medical Certification for FMLA - Family Member

Take this form to your family member's medical provider for certification.

For questions regarding this form call 877-[illegible]-FMLA/877-[illegible]-3652. Return to the FMLA Center by _____

Patient Name: John Smith (172) ***Relationship to Employee:*** SPOUSE (174)

Employee Name Janice Doe (148) ***SS No.:*** 123-45-6781 (150)

1 Reason for Leave — Medical Provider must check (✓) any and all that apply.

(142)

PREGNANCY — *I certify that the above patient is/has been/will be:*

- ☐ **Incapacitated*** due to pregnancy.
- ☐ Receiving prenatal care. — Expected delivery date: _____

MEDICAL CONDITION — *I certify that the above patient is/has been/will be:*

- ☐ **Incapacitated*** for **more than 3 consecutive days** and received **treatment at least 2 times** for this condition.
- ☐ **Incapacitated*** for **more than 3 consecutive days** and received **treatment** for this condition and prescribed a regimen of continuing treatment (i.e. therapy, Rx).
- ☐ **Incapacitated*** by or **out of work** to receive treatment for a **chronic** serious health condition which 1) requires **periodic visits/treatment** and 2) continues over extended period of time and 3) causes **episodic** or **continuing incapacity***.
- ☐ **Incapacitated*** by a **permanent/long-term condition** for which patient is undergoing continuing treatment (i.e. Alzheimer's, severe stroke).
- ☐ **Out of work** to undergo **examination/testing** for a condition that would likely fall into one of the categories listed above or require inpatient stay.

*** Unable to work or perform regular daily activities.**

HOSPITAL STAY — *I certify that the above patient is/has been/will be:*

- ☐ **Inpatient** in a **hospital, hospice, or residential** medical care **facility.**
- ☐ Out of work to receive **treatment** for a condition connected to previous inpatient stay.
- ☐ **Recovering** from inpatient stay and incapacitated (unable to work or perform regular daily activities).

2 Dates/Time of Leave — Medical provider must indicate dates and times of leave for the employee

(144)

Continuous Leave: (If Requested) — *I certify that the above employee is needed to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care), or parent for the following time period:*

Requested time period — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

Reduced Hours: (If Requested) — *I certify that the above employee needs reduced work hours to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care), or parent for the following time period:*

Requested reduced hours schedule _____ hrs./day _____ hrs./week _____ days/week

Requested time period — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

Intermittent (i.e., occasional, episodic) Leave: (If Requested) — *I certify that the above employee needs intermittent leave to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 of incapable of self-care), or parent for the following time period:*

Requested intermittent schedule _____ hrs./day _____ hrs./week _____ days/week

Indicate approximate duration of medical condition — Begin date: _____ (mm/dd/yy) to _____ (mm/dd/yy) end date

3 Signature Stamp — Medical provider must sign and return form to the FMLA Center

(146)

Medical Provider Signature: _____ (152) ***Phone:*** _____ (154) ***Fax:*** _____ (156)

Print Name: _____ (158) ***Type of Practice:*** _____ (160) (field of specialty, if any)

Address: _____ (162) (city) (state) (zip)

FIG. 5